

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

519

CERTIFICATE OF DEATH

00510

Reg. Dist. No. 116

Item 9, Film G193 2-24-56 et

| | | | | | | | |
|---|---|---|--|--|---|--|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) <u>13 TOWN Cambridge</u> | | LENGTH OF STAY (In this place) <u>15 mo.'s</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR RFD # 3, Cambridge, Md.</u> | | <u>X</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67 Cambridge Maryland Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Mc</u> (Middle) <u>Gregor</u> (Last) <u>Barnes</u> | | | | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>1</u> (Year) <u>19 56.</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH <u>3-5-1899</u> | 9. AGE last birthday <u>55</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Radiology</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Noble Barnes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Isabelle Mc Gregor</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>RFD # 3, Mrs. John M. Barnes, Cambridge, Md.</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) <u>Coronary Infarction late & old</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | <u>3 yrs.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Encephalomalacia</u> | | | | | | <u>3 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) M. <u> </u> <u> </u> <u> </u> | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept 8, 1954</u>, to <u>Jan 1, 1956</u>, that I last saw the deceased alive on <u>Jan 1, 1956</u>, and that death occurred at <u>4:28</u> M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. Barnes</u> | | | | ADDRESS (Street, city, town, state) <u>Cambridge</u> | | DATE SIGNED <u>1-1-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | DATE THEREOF <u>1-1-56</u> | | NAME OF CEMETERY OR CREMATORY <u>William Lee's Sons</u> | | LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 24. REC'D BY REGISTRAR DATE <u>Jan. 9, 1956</u> | | REGISTRAR'S SIGNATURE <u>John H. Hall, R.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Le Comte Funeral Service, Cambridge, Md.</u> | | | |

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

520

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00511

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|--|-----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Dorchester</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13 TOWN Cambridge</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>13 TOWN Cambridge</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 9 School House Lane</u> | | | | STREET ADDRESS (If rural give location) <u>9 School House Lane</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Rachel Bishop</u> | | 4. DATE OF DEATH: (Month) (Day) (Year) <u>Jan 21 1956</u> | | | | | |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH: <u>Sept. 29, 1900</u> | 9. AGE last birthday <u>55</u> yrs. | IF UNDER 1 YEAR Months Days Hours Mln. | IF UNDER 24 HRS. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Food Packing</u> | | 11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>James Bishop</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Rachel Bishop</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u> | | 16. SOCIAL SECURITY NO. <u>unk</u> | | 17. INFORMANT & ADDRESS: | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 443X IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u> | | | | | | | |
| ANTECEDENT CAUSE (S): (B) <u>Hypertensive Cardiovascular Disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 14, 1956</u> , to <u>Jan. 21, 1956</u> , that I last saw the deceased alive on <u>Jan. 21, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. Edwin Fassett</u> | | ADDRESS <u>J. Edwin Fassett, M.D.-227 Fine St-Camb., Md.-1-25-56</u> | | DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-28-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Taylor's Island Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Taylor's Island, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>Jan. 27, 1956</u> | | REGISTRAR'S SIGNATURE <u>John M. ...</u> | | 24. FUNERAL DIRECTOR <u>H.M. St. Clair, Jr.,</u> | | ADDRESS <u>High St-Camb. Md</u> | |

UNITED STATES OF AMERICA

BUREAU V. S.

JAN 30 1956

RECEIVED

521

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <i>Dorchester</i> | MARYLAND | STATE <i>Maryland</i> | COUNTY <i>Dorchester</i> |
| CITY (If outside corporate limits, write RURAL OR TOWN) <i>Cambridge</i> | LENGTH OF STAY (in this place) <i>2 years</i> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Surlock</i> X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Greenbush Nursing Home</i> | STREET ADDRESS (If rural give location) <i>1</i> | | |
| 3. NAME OF DECEASED: (Type or Print) (First) <i>George</i> (Middle) <i>B.</i> (Last) <i>Blake</i> | | 4. DATE (Month) (Day) (Year) OF DEATH <i>Jan. 15 1956</i> | |
| 5. SEX: <i>male</i> | 6. COLOR OR RACE: <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Widowed</i> | 8. DATE OF BIRTH: <i>Nov 13, 1875</i> |
| 9. AGE last birthday <i>80</i> yrs. | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| | | Months | Days |
| | | Hours | Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life) <i>Team Driver Manager</i> | | 10B. KIND OF BUSINESS OR INDUSTRY: <i>Team Manager</i> | 11. BIRTHPLACE (State or foreign country): <i>Talbot Co. Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 13. FATHER'S NAME: <i>Theodore Blake</i> | |
| 14. MOTHER'S MAIDEN NAME: <i>Lansie N. Berry</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <i>216-03-7504A</i> | | 17. INFORMANT & ADDRESS: <i>Council Blake, Harmsburg Home</i> | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| 420.1 IMMEDIATE CAUSE (A) <i>Coronary occlusion</i> | | | <i>4 days</i> |
| ANTECEDENT CAUSE (S) DUE TO (B) <i>Coronary Heart Disease</i> | | | <i>2 yrs.</i> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Peripheral Vascular Disease</i> | | | <i>2 yrs</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>3/29, 1955</i> , to <i>1/15, 1956</i> ; that I last saw the deceased alive on <i>1/14, 1956</i> , and that death occurred at <i>4:35 A</i> M, from the causes and on the date stated above. | | | |
| SIGNATURE <i>Lawrence Maryanor</i> | | M. D. <i>Cambridge, Md</i> DATE SIGNED <i>1/17/56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>Jan 17, 1956</i> | |
| NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i> | | LOCATION (City, town, or county) (State) <i>Eastern Maryland</i> | |
| DATE REC'D BY LOCAL REGISTRAR <i>Jan. 17, 1956</i> | | REGISTRAR'S SIGNATURE <i>John H. H.</i> | |
| 24. FUNERAL DIRECTOR <i>Maurice E. Newman & Son</i> | | ADDRESS | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 18 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

522

00513
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> TOWN <u>Cambridge</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cambridge</u> | | <u>13</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md. Hospital</u> | | | | STREET ADDRESS (If rural, give location) <u>115 Pine St.</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>LOTTIE C. BOGGS</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 11, 1956</u> | | | |
| 5. SEX: <u>Female</u> | | 6. COLOR OR RACE: <u>Negro</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u> | | 8. DATE OF BIRTH: <u>Feb. 17, 1888</u> | |
| 9. AGE last birthday: <u>67</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME: <u>James W. Cornish</u> | | | |
| 14. MOTHER'S MAIDEN NAME: <u>Sophie Stewart</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY No.: | | | | 17. INFORMANT & ADDRESS: <u>Charles Cornish: Cambridge, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>812X</u> Immediate cause (a) <u>Subarachnoid Hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>Shock</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) | | | | | | <u>Approx. 4-5</u> <u>24 hrs.</u> | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | |
| <u>2</u> | | | | <u>2</u> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Pine St.</u> | | 21c. (City or town) (County) (State) <u>Cambridge Dorchester Md.</u> | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 11, 1956 8:30 AM</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Struck by a car.</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>John Moore</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>Jan. 16, 1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>Jan. 15, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>Jan. 15, 1956</u> | | REGISTRAR'S SIGNATURE <u>John Moore</u> | | 24. FUNERAL DIRECTOR <u>Herbert M. St. Clair</u> | | ADDRESS <u>Cambridge, Md.</u> | |

BUREAU V. S.

JAN 18 1956

RECEIVED

523

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00514

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|-----------------------------------|---|---|--|--------------------------------|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) 13 TOWN <u>Cambridge</u> | | LENGTH OF STAY (in this place) Life | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hospital</u> | | | | STREET ADDRESS (If rural give location) RFD #2 | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Russell</u> <u>Leon</u> <u>Brown</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>17</u> <u>1956</u> | | | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>January 1, 1901</u> | 9. AGE last birthday <u>54</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Food Packing</u> | | 11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Stephen Brown</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Emily Stevens</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) <u>unk</u> | | 16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>unk</u> | | 17. INFORMANT & ADDRESS: <u>Elsie Brown, R.F.D.#2, Cambridge, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Acute Myocardial infarction</u> | | | | | | | |
| ANTECEDENT CAUSE (S): DUE TO (B) <u>Coronary Heart Disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Massive Pulmonary Edema</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 10, 1956</u> , to <u>Jan. 17, 1956</u> , that I last saw the deceased alive on <u>Jan. 17, 1956</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. SIGNATURE <u>J. Edwin Fassett</u> ADDRESS <u>227 Pine St-Camb., Md.</u> DATE SIGNED <u>1-23-56</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-22-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Linas Road Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Linas Road-Dor-Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>Jan. 22, 1956</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 24. FUNERAL DIRECTOR <u>H.M. St. Clair, Jr.</u> | | ADDRESS <u>-High St-Camb., Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

253

BUREAU V. S.

JAN 26 1956

RECEIVED

00515

537

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 116

| | | | | | | | |
|--|--|---|--|--|--|-------------------------------------|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | OR TOWN | |
| <input checked="" type="checkbox"/> TOWN <u>Cambridge, Rural</u> | | <u>2 years</u> | | <u>Cambridge, R.D. 1</u> | | <input checked="" type="checkbox"/> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge, R.D. 1</u> | | | | STREET ADDRESS (If rural, give location) <u>Cambridge R.D. 1</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) | | (First) <u>Thomas</u> | | (Middle) <u>Ryan</u> | | (Last) <u>Coates</u> | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | | 8. DATE OF BIRTH: | |
| <u>Male</u> | | <u>White</u> | | <u>Married</u> | | <u>Oct. 5, 1888</u> | |
| 9. AGE last birthday: | | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>67 yrs.</u> | | <u>Retired Machinist</u> | | <u>Buena Vista, Pa.</u> | | <u>U.S.</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>Joseph Coates</u> | | | | <u>Hannah Logan</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | | 18. MEDICAL CERTIFICATION | |
| <u>no</u> | | <u>no</u> | | <u>169-01-3449</u> | | <u>R.D. 1</u> | |
| | | | | <u>Mrs. Bessie B. Coates, Cambridge, Md.</u> | | | |

| | | | | | |
|--|--|---|--|---|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO | | | | | |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | |
| <u>0</u> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | |
| <input type="checkbox"/> | | <input type="checkbox"/> | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| <input type="checkbox"/> | | <input type="checkbox"/> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED | | | |
| <u>John M. [Signature]</u> | | <u>Jan. 23, 1956</u> | | | |
| 23. BURLIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| <u>Burial</u> | | <u>Jan. 26, 1956</u> | | <u>Mt. Vernon Cemetery</u> | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | |
| <u>Jan. 23, 1956</u> | | <u>John Thaw</u> | | <u>Kenneth R. Thomas, Cambridge, Md.</u> | |
| | | | | <u>Hunter, Edmundson & Striffler</u> | |
| | | | | <u>McKeesport, Pa.</u> | |

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

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MARYLAND

STATE DEPARTMENT OF HEALTH

524

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | |
|--|-------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write OR give nearest town) <u>Cambridge</u> | | CITY (If outside corporate limits, write OR give nearest town) <u>East New Market</u> | |
| TOWN <u>Cambridge Maryland</u> | | TOWN <u>East New Market</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) <u>Edith Seidler Collins</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1/1/1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Widowed</u> | 8. DATE OF BIRTH <u>6/15-1880</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | |
| 13. FATHER'S NAME <u>Carl Seidler</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Schutzie</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 17. INFORMANT AND ADDRESS <u>Germa Seidler Washington D.C.</u> | |
| 16. SOCIAL SECURITY NO. | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |

| | | | |
|---|---|---|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION <u>Coronary occlusion</u> | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> |
| (a) Immediate cause <u>420.1</u> | | | |
| (b) Antecedent cause(s) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> | | | |
| (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u> | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u> | (CITY OR TOWN) | (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 12/31, 1955, to 1/1, 1956, that I last saw the deceased alive on 12/31, 1955, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

| | | | | |
|--|--|--|---|---------------------------|
| SIGNATURE <u>Lawrence Maryanov M.D.</u> | | ADDRESS <u>Cambridge, Md.</u> | | DATE SIGNED <u>1/4/56</u> |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | DATE <u>1/3/56</u> | NAME OF CEMETERY OR CREMATORY <u>East New Market</u> | LOCATION (City, town, or county) <u>East New Market Md.</u> | (State) |
| DATE REC'D BY LOCAL REG. <u>Jan. 3, 1956</u> | REGISTRAR'S SIGNATURE <u>John Thaw, R.D.</u> | 24. FUNERAL DIRECTOR <u>Luck S. Miloughby</u> | ADDRESS <u>East New Market, Md.</u> | |

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00517

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|-----------------------------------|---|--|--|---|--|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Dorchester</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Smithsville</u> | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Smithsville</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Fred</u> <u>Lincoln</u> <u>Cornish</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan.</u> <u>27</u> , <u>1956</u> | | | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>Feb. 8, 1886</u> | 9. AGE last birthday <u>69</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Food Packing</u> | | 11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Adam Cornish</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Annie Wilson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ----- | | 16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) ----- <u>207-07-1429</u> | | 17. INFORMANT & ADDRESS: <u>Annie Ward, Smithsville, Dor. Co., Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 442X IMMEDIATE CAUSE (A) <u>Stroke</u> DUE TO | | | | | | | |
| ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Systemic arteriosclerosis C.V.D.</u> DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 27, 1956</u> , to <u>Jan 27, 1956</u> , that I last saw the deceased alive on <u>Jan 27, 1956</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James H. Thompson</u> | | | | ADDRESS <u>Cambridge, Md.</u> M. D. <u>Jan 30, 1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1/31/1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Smithsville Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Smithsville, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>Jan. 30, 1956</u> | | REGISTRAR'S SIGNATURE <u>John H. D.</u> | | 24. FUNERAL DIRECTOR <u>H.M. St. Clair, Jr.</u> | | ADDRESS <u>Cambridge, Md.</u> | |

CONSTITUTION OF THE STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

ARTICLE I. OF THE CONSTITUTION.

SECTION 1. The General Assembly shall consist of a Senate and a House of Delegates. The Senate shall be composed of members elected by the people of the State, and the House of Delegates shall be composed of members elected by the people of the State.

SECTION 2. The General Assembly shall have the power to pass laws, to levy taxes, and to appropriate money for the public use. It shall also have the power to impeach and remove from office any officer of the State.

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BUREAU V. S.

SECTION 3. The Executive Power shall be vested in the Governor of the State. He shall be elected by the people for a term of four years, and shall have the honor and privilege of the office.

SECTION 4. The Judicial Power shall be vested in the Supreme and Circuit Courts of the State. The Supreme Court shall be composed of a Chief Justice and four Associate Justices, and the Circuit Courts shall be composed of a Judge and two Associates.

525

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Dorchester</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Dorchester</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> | LENGTH OF STAY (in this place) <u>Sev.mos.</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72 Washington Street</u> | | STREET ADDRESS (If rural give location) <u>72 Washington Street</u> | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH: | |
| (First) <u>Rev. James</u> | (Middle) <u>A.</u> | (Last) <u>Fassett</u> | (Month) <u>Jan.</u> (Day) <u>17</u> (Year) <u>1956</u> |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u> | 8. DATE OF BIRTH: <u>Aug. 13, 1891</u> |
| 9. AGE last birthday <u>64 yrs.</u> | | 10. BIRTHPLACE (State or foreign country): <u>Berlin, Maryland</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Minister</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Joshua Fassett</u> | | 14. MOTHER'S MAIDEN NAME: <u>Aralanta Showell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>None</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Josephine Fassett, Berlin, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| 153X IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis</u> | | | <u>3 mos.</u> |
| ANTECEDENT CAUSE (S): (B) <u>Carcinoma colon, right</u> | | | <u>Unknown</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <u>Sept. 1, 1955</u> | | 19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of colon, right with metastases</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Jan 8, 1956</u> to <u>Jan 17, 1956</u> , that I last saw the deceased alive on <u>Jan 8, 1956</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>Lavinia M. Burdette</u> | | DATE SIGNED <u>City Office Bldg., Cambridge, Md.</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Jan. 22, '56</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Flowers St. Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Berlin, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>January 23, 1956</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>H. M. St. Clair, Jr., Cambridge, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
BUREAU OF PUBLIC HEALTH

505

BUREAU V. B.

JAN 24 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

| | | | | | |
|---|--------------------------------|---|---|----------------------------|--------------------------------------|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY | Dorchester | | STATE | Maryland COUNTY Dorchester | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) OR | | |
| TOWN | Cambridge | 4 Mo. | TOWN | Church Creek | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Eastern Shore State Hospital | | STREET ADDRESS | (If rural, give location) | |
| 3. NAME OF DECEASED: | | | 4. DATE OF DEATH | | |
| (First) | (Middle) | (Last) | (Month) | (Day) | (Year) |
| Joseph S | | Fitzhugh | Jan. | 7 | 19 55 |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. |
| M | White | M | Nov 26, 1882 | 73 yrs. | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? |
| Waterman | | Water | Maryland | | U.S. |
| 13. FATHER'S NAME: | | | 14. MOTHER'S MAIDEN NAME: | | |
| Joseph Fitzhugh | | | Amanda Dean | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: | | |
| No | | - | Records Eastern Shore State Hosp. | | |

| | | | | |
|---|--|--|-------------------------------|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | |
| 493x Immediate cause (a).....Pneumonia DUE TO Antecedent cause(s) (b).....Fracture left femur Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)..... II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Ch. brain syndrome | | | | 1 wk. 2 mo. ? |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | 21c. (City or town) (County) | (State) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 09 11-10-55 2pM. | | Fell to floor. | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <input checked="" type="checkbox"/> 1/8/56 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| Burial | | 1-10-56 | DORCHESTER MEM. PK. | Cambridge, Md. |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR ADDRESS |
| Jan. 10, 1956 | | John Thayer, M.D. | | McCompte FUNERAL SERVICE Cambridge, Md. Pm J.D. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

RECEIVED

526
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 116

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cambridge</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>183 Washington St.</u> | | | | STREET ADDRESS (If rural, give location) <u>183 Washington St.</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>SARAH</u> | | (Middle) <u>FLOYD</u> | | (Last) | | (Month) (Day) (Year) <u>1/ 6/ 1956</u> | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | | 8. DATE OF BIRTH: | |
| <u>Female</u> | | <u>Negro</u> | | <u>M</u> | | <u>April 25, 1899</u> | |
| 9. AGE last birthday: | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| <u>56</u> yrs. | | Months Days Hours Min. | | <u>7/1</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME: <u>Jerry Paine</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Hester Paine</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY No.: <u>218-20-7138</u> | | 17. INFORMANT & ADDRESS: <u>Mr. James Travers: RFD #3, Cambridge, Md.</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) | | | | | | ? | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>John Mace</u> | | | | DATE SIGNED <u>1-9-1956</u> | | | |
| M. D. <u>John Mace, M.D. Cambridge, Md.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Jan 9 1956</u> | | <u>Bethel Cemetery</u> | | <u>Cambridge, Md.</u> | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | | | |
| <u>Herbert StClair: Cambridge, Md.</u> | | | | | | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JAN 10 1902

RECEIVED

527

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|-------------------------------|--|-------------------------------------|--|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Dorchester</i> | | MARYLAND | | STATE <i>Md</i> | | COUNTY <i>Dorchester</i> | |
| CITY (If outside corporate limits, write RURAL or end give nearest town) <i>Cambridge</i> | | LENGTH OF STAY (in this place) <i>1 day</i> | | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i> | | | |
| TOWN <i>Cambridge</i> | | | | STREET ADDRESS (If rural give location) <i>207 Academy St.</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Cambridge-hrd Hospital</i> | | | | | | | |
| 3. NAME OF DECEASED (First) <i>William</i> (Middle) (Last) <i>Fries</i> | | | | 4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>25</i> (Year) <i>1956</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i> | 8. DATE OF BIRTH <i>MAR. 3 1988</i> | 9. AGE last birthday <i>67</i> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired filling station owner</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>NEW JERSEY</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S</i> | |
| 13. FATHER'S NAME <i>James Fries</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Ethel Graham</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. <i>220-07-0808</i> | | 17. INFORMANT & ADDRESS <i>Richard G. Fries Cambridge, Md.</i> | | | |
| | | (If Yes, give war or dates of service) | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.0 IMMEDIATE CAUSE (A) <i>Coronary occlusion</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Heart Disease</i> | | | | | | <i>1 yr</i> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Atherosclerotic Heart Disease</i> | | | | | | <i>1 yr</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>1/25</i>, 19<i>56</i>, to <i>1/25</i>, 19<i>56</i>; that I last saw the deceased alive on <i>1/25</i>, 19<i>56</i>, and that death occurred at <i>12:15 p</i>.M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Lawrence Maryanov</i> M.D. | | | | ADDRESS (Street, city, town, state) <i>Cambridge, Md.</i> | | DATE SIGNED <i>1/27/56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>1/28/56</i> | | NAME OF CEMETERY OR CREMATORY <i>Offord Cemetery</i> | | LOCATION (City, town, or county) (State) <i>Offord Md.</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <i>John Mace, Jr.</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Leonard</i> | | ADDRESS <i>Easton Md</i> | |
| DATE <i>Jan. 31, 1956</i> | | | | | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

540
CERTIFICATE OF DEATH

Reg. Dist. No. 110

| | | | | | | | |
|--|-----------------------------------|--|---|--|---------------------------|---|-------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Federalsburg - Rural</u> | | LENGTH OF STAY (In this place) <u>Life</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Federalsburg - Rural</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Cokesbury</u> | | | | STREET ADDRESS (If rural give location) <u>Near Cokesbury</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Perry Lee Hackett</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>January 10 1956</u> | | | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | 8. DATE OF BIRTH: <u>April 6, 1873</u> | 9. AGE last birthday <u>82</u> yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Farmer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm Owner</u> | | 11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Perry G. Hackett</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Priscilla Tull</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS: <u>Mrs. Alice L. Hackett, Seaford, Del. RFD</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE <u>420.0</u> | | | | | | | |
| ANTECEDENT CAUSE (S) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (A) <u>Arteriosclerotic Heart Disease</u> | | | | | | <u>6 yrs -</u> | |
| (B) <u>Coronary atherosclerosis with myocardial infarction</u> | | | | | | <u>16 months</u> | |
| (C) <u>Myocardial failure</u> | | | | | | <u>1 mo.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>mar</u> , 1949, to <u>Jan 10</u> , 1956, that I last saw the deceased alive on <u>Jan 9</u> , 1956, and that death occurred at <u>4:40A</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. Heland Jr. M.D.</u> | | | | ADDRESS <u>Seaford, Delaware</u> | | DATE SIGNED <u>Jan. 10, 1956</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Jan. 12, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Cokesbury Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Near Federalsburg, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>Jan 12-1956</u> | | REGISTRAR'S SIGNATURE <u>Charles Hastings</u> | | 24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u> | | ADDRESS | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 17 1956

BUREAU V. S.

528

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|-------------------|--|--|--|-----------------|--|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Dorchester</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR | | | |
| 13 TOWN <u>Cambridge</u> | | 1 week | | TOWN <u>Bishops Head</u> X | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 67 Cambridge Md. Hospital | | | | 1 | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | 4. DATE (Month) (Day) (Year) | | | | |
| DECEASED: (Type or Print) <u>GRACE</u> <u>PHILLIPS</u> <u>JOHNSON</u> | | | OF DEATH: <u>Jan</u> <u>17</u> <u>1956</u> | | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>Female</u> | <u>White</u> | <u>Widowed</u> | <u>8-28-1889</u> | <u>66</u> yrs. | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | <u>Seafood</u> | | <u>Hoopers Island, Maryland</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>John R. Phillips</u> | | | | <u>Not Known</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | | | |
| <u>No</u> (If Yes, give war or dates of service) | | <u>218-01-5253</u> | | <u>Mr. Herman Tolley Bishops Head, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 154X IMMEDIATE CAUSE (A) <u>Diffuse Peritonitis</u> | | | | | | <u>7 days.</u> | |
| ANTECEDENT CAUSE (S): (B) <u>Perforation of Sigmoid Colon.</u> | | | | | | <u>7 days.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma of Sigmoid</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | |
| <u>2</u> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? | | (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1/10</u> , 19 <u>56</u> , to <u>1/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/17</u> , 19 <u>56</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | M. D. <u>Cambridge, Md</u> | | DATE SIGNED <u>1-18-1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>1-19-1956</u> | | <u>St. Thomas Church Yard</u> | | <u>Bishops Head, Dor. Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>Jan 19, 1956</u> | | <u>John Nae, M.D.</u> | | <u>LeCompte Funeral Service</u> | | <u>Cambridge, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 28 1956

RECEIVED

MARYLAND

541

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor.</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Church Creek</u> LENGTH OF STAY (In days) <u>7</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Church Creek, Md.</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) <u>Carl</u> (First) <u>Neal</u> (Middle) <u>Jones</u> (Last) | | 4. DATE OF DEATH (Month) <u>1</u> (Day) <u>29</u> (Year) <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u> | 8. DATE OF BIRTH <u>6/11/1873</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter, Ret.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday <u>82</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Jones</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen Richardson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT AND ADDRESS <u>Hellie Jones</u> <u>Church Creek, Md.</u> | | | |

| | | |
|---|--|---|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs.</u> <u>8 mos.</u> |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| <p>420.0 (a) <u>Uremia</u></p> <p>Antecedent cause(s)</p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u></p> <p>(c) <u>Cerebral hemorrhage</u></p> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 7-7-, 1953, to 1-29-, 1956 that I last saw the deceased

alive on 1-7-56, 1956, and that death occurred at 8:15 a.m., from the causes and on the date stated above.

SIGNATURE Robert B. Baker M.D. (Degree or Title) ADDRESS 9 Rose St., Cambridge Md. DATE SIGNED 7/25

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 7/31/56 NAME OF CEMETERY OR CREMATORY Washington LOCATION (City, town, or county) (State) Dorchester, Md.

DATE REC'D BY LOCAL REGISTRY Jul. 1, 1956 REGISTRAR'S SIGNATURE J. H. Moore, M.D. 24. FUNERAL DIRECTOR South S. Wollongby ADDRESS East New Market, Md.

RECEIVED

FEB 10 1956

BUREAU V. S.

529

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write OR and give nearest town) | | RURAL | | CITY (If outside corporate limits, write OR and give nearest town) | | RURAL | |
| TOWN <u>Cambridge</u> | | LENGTH OF STAY (in this place) <u>Life</u> | | TOWN <u>Cambridge</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Bethel Street</u> | | | | STREET ADDRESS (If rural give location) <u>9 Bethel Street</u> | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE (Month) (Day) (Year) | | | |
| (First) <u>Samuel</u> | | (Middle) | | (Last) <u>Locks</u> | | OF DEATH: <u>1</u> <u>2</u> <u>19 56</u> | |
| 5. SEX: <u>Male</u> | | 6. COLOR OR RACE: <u>Negro</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u> | | 8. DATE OF BIRTH: <u>Nov-15-1875</u> | |
| 9. AGE last birthday <u>80</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>- - -</u> | | 11. BIRTHPLACE (State or foreign country): <u>Dor-County-Md.</u> | |
| 13. FATHER'S NAME: <u>Jeremia Locks</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Lizzie Locks</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u> | | | | 16. SOCIAL SECURITY NO. <u>unk</u> | | 17. INFORMANT & ADDRESS: <u>Annie Kane, Cambridge, Maryland</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u> | | | | | | | |
| ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerotic Heart</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Disease</u> | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>0</u> | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Mar. 29, 1954</u> to <u>Jan. 2, 1956</u> , that I last saw the deceased alive on <u>Jan. 2, 1956</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. J. EDWIN FASSETT</u> | | ADDRESS <u>227 Pine St-Camb., Md.</u> | | DATE SIGNED <u>1-4-56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-8-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cambridge-Dor-Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>1-8-1956</u> | | REGISTRAR'S SIGNATURE <u>John H. ...</u> | | 24. FUNERAL DIRECTOR <u>H.M. StClair, Jr.</u> | | ADDRESS <u>High St-Camb., Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VALLEY'S
CONGRESS
BOND

BUREAU V. S.

JAN 11 1956

RECEIVED

542

CERTIFICATE OF DEATH

Reg. Dist. No. 110

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Dorchester</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Dorchester</u> |
| CITY (If outside corporate limits, write RURAL or give nearest town) TOWN <u>Rhodesdale - Rural</u> | LENGTH OF STAY (in this place) <u>9 years</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rhodesdale - Rural</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eldorado</u> | | STREET ADDRESS (If rural give location) <u>Eldorado</u> | |
| 3. NAME OF DECEASED: | | 4. DATE (Month) (Day) (Year) | |
| (First) <u>George</u> | (Middle) <u>Wesley</u> | (Last) <u>Murphy</u> | OF DEATH: <u>January 11 1956</u> |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | 8. DATE OF BIRTH: <u>November 11, 1883</u> |
| 9. AGE last birthday <u>72</u> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Stationary Engineer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: | |
| 11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>John N. Murphy</u> | | 14. MOTHER'S MAIDEN NAME: <u>Rebecca Rhodes</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u> | | 16. SOCIAL SECURITY NO. <u>089-05-8018</u> | |
| 17. INFORMANT & ADDRESS: <u>Mrs. Florence E. Murphy, Rhodesdale, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | <u>1 hour</u> | |
| IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> | | | |
| ANTECEDENT CAUSE (S) (B) <u>Coronary Disease</u> | | <u>5 years +</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Oct.</u> , 19 <u>55</u> , to <u>January 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>January 9, 1956</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>W. C. Harrison</u> | | M. D. <u>Hurlock, Maryland</u> Jan. 13, 1956 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Jan. 13, 1956</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Eldorado Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Eldorado, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>Jan 13 1956</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>J.J. Frampton and Son, Federalsburg, Md.</u> | |

MARGIN RESERVED FOR BINDING

RECEIVED

JAN 29 1956

BUREAU V. B.

543

00526
Reg. Dist. 116
No. 200

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|----------------------------|--|-----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Dorchester | | MARYLAND | | STATE Maryland COUNTY Kent County | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Cambridge | | LENGTH OF STAY (In this place) 1 mo. & 24 das. | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Chestertown, Md. 14-97-2 | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital | | | | STREET ADDRESS (If rural, give location) --- | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Martha Jane Othoson | | | | 4. DATE OF DEATH (Month) (Day) (Year) Jan. 9 19 56 | | | |
| 5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W | 8. DATE OF BIRTH: 7-6-1866 | 9. AGE last birthday: 89 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None | | 10b. KIND OF BUSINESS OR INDUSTRY: -- | | 11. BIRTHPLACE (State or foreign country): Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME: William J. Hurlock | | | | 14. MOTHER'S MAIDEN NAME: Mary Gordon | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) -- | | 16. SOCIAL SECURITY No.: -- | | 17. INFORMANT & ADDRESS: Eastern Shore State Hospital Records | | | |

| | | |
|---|--|--|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| <p>904.7 Immediate cause (a) Myocardial failure DUE TO</p> <p>Antecedent cause(s) (b) Proton neck R. femur DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p> | | |
| <p>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p> | | |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | |
|---|--|---|--|
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Home | 21c. (City or town) (County) (State) Chestertown, Md. |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 12-10-55 3P. M. | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? Fell to floor | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| SIGNATURE John Mace Jr. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 9, 1956 ASSISTANT MEDICAL EXAM. | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Jan. 12, 1956 | NAME OF CEMETERY OR CREMATORY: Still Pond Cem. | LOCATION (City, town, or county) (State): Still Pond, Md. |
| DATE REC'D BY LOCAL REG. Jan. 9, 1956 | REGISTRAR'S SIGNATURE: Edward Fellows | 24. FUNERAL DIRECTOR: Edward Fellows, Mellington, Md. | |

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1956

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C N55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

544

CERTIFICATE OF DEATH

00527

Reg. Dist. No. 116

| | | | |
|--|--------------------------------|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Dorchester</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Wicomico</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN <u>Cambridge</u> | | TOWN <u>Salisbury</u> | 22 X-2 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| <u>Eastern Shore State Hospital</u> | | <u>Rt. 3</u> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| <u>John William Parsons</u> | | <u>Jan 21 1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>1883</u> |
| | | 9. AGE last birthday <u>72</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer--</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>on Own Farm</u> | 11. BIRTHPLACE (State or foreign country) <u>Md Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>US A</u> | | | |
| 13. FATHER'S NAME <u>John Henry Parsons</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Ellen</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT & ADDRESS <u>Mr. Harold T. Parsons (Son) R.D.#3 Salisbury, Md</u> <u>Hospital Records, Cambridge, Md</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>Broncho Pneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 3 56</u> , 19 <u>56</u> , to <u>Jan 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>56</u> , and that death occurred at <u>9:55</u> M, from the causes and on the date stated above. | | | |
| SIGNATURE <u>James T. Dudge</u> M.D. | | DATE SIGNED <u>Jan 21 56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | NAME OF CEMETERY OR CREMATORY <u>Bethel Cem.</u> | |
| DATE THEREOF <u>Jan 24-56</u> | | LOCATION (City, town, or county) <u>Salisbury Md</u> | |
| 24. REC'D BY REGISTRAR <u>John Mace, Jr.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Hollingsworth & Maltz</u> | |
| DATE <u>JAN 25 1956</u> | | ADDRESS <u>Salisbury Md</u> | |

CERTIFICATE OF DEATH

544

Reg. Dist. No.

1. REGISTRATION DISTRICT (NUMBER OF DISTRICT)

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. NAME OF DECEASED

6. SEX

7. RACE

8. AGE

9. OCCUPATION

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF NEXT OF KIN

19. SIGNATURE OF BURIAL

20. SIGNATURE OF CREMATION

21. SIGNATURE OF INTERMENT

22. SIGNATURE OF REINTERMENT

23. SIGNATURE OF EXHUMATION

24. SIGNATURE OF REINTERMENT

25. SIGNATURE OF EXHUMATION

26. SIGNATURE OF REINTERMENT

27. SIGNATURE OF EXHUMATION

28. SIGNATURE OF REINTERMENT

29. SIGNATURE OF EXHUMATION

30. SIGNATURE OF REINTERMENT

31. SIGNATURE OF EXHUMATION

32. SIGNATURE OF REINTERMENT

33. SIGNATURE OF EXHUMATION

34. SIGNATURE OF REINTERMENT

35. SIGNATURE OF EXHUMATION

36. SIGNATURE OF REINTERMENT

37. SIGNATURE OF EXHUMATION

38. SIGNATURE OF REINTERMENT

39. SIGNATURE OF EXHUMATION

40. SIGNATURE OF REINTERMENT

41. SIGNATURE OF EXHUMATION

42. SIGNATURE OF REINTERMENT

43. SIGNATURE OF EXHUMATION

44. SIGNATURE OF REINTERMENT

BUREAU V. S.

JAN 30 1956

RECEIVED

ENCLOSURE

RECEIVED JAN 30 1956

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

530

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00528

CERTIFICATE OF DEATH

Reg. Dist. No. 176

| | | | | | | | |
|--|--------------------------------|--|--|---|-----------------------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Dorchester</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Vienna</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>RFD #1</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Della</u> <u>Pinder</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>22</u> <u>1956</u> | | | |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | 8. DATE OF BIRTH: <u>July 15, 1898</u> | 9. AGE last birthday <u>57</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u> | | 11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Joseph Stiles</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Georgianna Parker</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>- - -</u> (If Yes, give war or dates of service) <u>- - -</u> | | 16. SOCIAL SECURITY NO. <u>219-07-7193</u> | | 17. INFORMANT & ADDRESS: <u>Minnie Young-Cambridge, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Confluent Bronchopneumonia Bilateral</u> | | | | | | | |
| ANTECEDENT CAUSE (S) DUE TO (B) <u>Gangrene right great toe</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>Jan 1955</u> | | 19B. MAJOR FINDINGS OF OPERATION: <u>Gangrene Left leg</u> | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Oct 19, 1953</u> , to <u>Jan 22, 1956</u> , that I last saw the deceased alive on <u>Jan 22</u> , 1956, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. Edwin Fassett</u> | | ADDRESS <u>227 Pine St-Cambridge, Md.</u> | | DATE SIGNED <u>1-27-56</u> | | | |
| 23. BURIAL, CRIMINATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-26-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Fork Neck Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Fork Neck, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>Jan. 24, 1956</u> | | REGISTRAR'S SIGNATURE <u>J. H. H. H.</u> | | 24. FUNERAL DIRECTOR <u>H.M. St. Clair, Jr.</u> | | ADDRESS <u>Cambridge, Md.</u> | |

UNITED STATES OF AMERICA

389

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

STATE OF NEW YORK
COUNTY OF ALBANY
CITY OF ALBANY

DECEASED
NAME
AGE
SEX
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

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BUREAU V. S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

545

00529

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 116

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Talbot</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | | |
| X TOWN <u>Cambridge</u> | | <u>11 mos. 15 days</u> | | TOWN <u>Wye Mills</u> | | <u>20x-2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u> | | | | STREET ADDRESS (If rural, give location) <u>---</u> | | | |
| 3. NAME OF DECEASED: (First) <u>Donald</u> | | (Middle) <u>--</u> | | (Last) <u>Rathell</u> | | 4. DATE OF DEATH <u>January 4 1956</u> | |
| 5. SEX: <u>Male</u> | | 6. COLOR OR RACE: <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | | 8. DATE OF BIRTH: <u>4-24-1894</u> | |
| 9. AGE last birthday: <u>61</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>---</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME: <u>Charles Rathell</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Minnie Donaldson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u> | | (If Yes, give war or dates of service) <u>---</u> | | 16. SOCIAL SECURITY No.: <u>---</u> | | 17. INFORMANT & ADDRESS: <u>RECORDS: Eastern Shore State Hospital</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>420.1</u> <u>Coronary occlusion</u> | | | | | | <u>Instant</u> | |
| Immediate cause (a) DUE TO | | | | | | | |
| Antecedent cause(s) (b) DUE TO | | | | | | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral arteriosclerosis</u> | | | | | | <u>?</u> | |
| 19a. DATE OF OPERATION: <u>0</u> | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>John M. ...</u> | | M. D. <u>...</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/4/56</u> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>1-7-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Shenandoah Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Bellevue, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>Jan. 5, 1956</u> | | REGISTRAR'S SIGNATURE <u>John M. ...</u> | | 24. FUNERAL DIRECTOR <u>W. Hampton Canold</u> | | ADDRESS <u>Easton, Md.</u> | |

BUREAU V. S.

JAN 9 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00530

531

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|--|------------------|--|------------------|--|-----------------|--|-----------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 13 TOWN <u>Cambridge</u> | | 4 Weeks | | Cambridge Rural | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 67 <u>Cambridge Md. Hospital</u> | | | | R.F.D. #3 | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>ROLAND</u> (Middle) <u>J.</u> (Last) <u>SEWARD</u> | | | | 1 12 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | |
| Male | White | W | 3-30-1888 | 67 yrs. | Months | Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Waterman | | Seafood | | Neck Dist Dor. Co., Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| James Seward | | | | Ella Todd | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | None | | Harvey E. Seward R.F.D. #3 Camb. Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 331X IMMEDIATE CAUSE (A) <u>Myocardial Failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis generalized</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Hemorrhage</u> | | | | 5 Wks | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city, town, state) <u>Cambridge Md</u> DATE SIGNED <u>1/16/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 1-15-56 | | Dorchester Memorial park | | Cambridge Dorchester Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | | |
| DATE <u>Jan. 15, 1956</u> | | <u>John Phay, R.D.</u> | | <u>LeCompte Funeral Service</u> Cambridge, Md. | | | |

RECEIVED

1. The report of the death of a person is a legal document and should be filled out as completely as possible. It is a record of the death and is used for many purposes, including the determination of the cause of death, the location of the body, and the identity of the deceased. It is also used for the purpose of determining the time and place of death, and for the purpose of determining the identity of the deceased. The report should be filled out as completely as possible, and should be signed by the person who has the best knowledge of the facts of the death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1956

Reg. No. 100

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. TIME OF DEATH

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. SEX

9. RACE

10. OCCUPATION

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. SOCIAL SECURITY NUMBER

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. CAUSE OF DEATH

19. MANNER OF DEATH

20. TIME OF DEATH

21. PLACE OF BIRTH

22. DATE OF BIRTH

23. SEX

24. RACE

25. OCCUPATION

26. MARITAL STATUS

27. EDUCATION

28. RELIGION

29. SOCIAL SECURITY NUMBER

30. DATE OF DEATH

31. TIME OF DEATH

32. PLACE OF DEATH

33. CAUSE OF DEATH

34. MANNER OF DEATH

35. TIME OF DEATH

36. PLACE OF BIRTH

37. DATE OF BIRTH

38. SEX

39. RACE

40. OCCUPATION

41. MARITAL STATUS

42. EDUCATION

43. RELIGION

44. SOCIAL SECURITY NUMBER

BUREAU V. S.

JAN 18 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

546

CERTIFICATE OF DEATH

00531

Reg. Dist. No. 116

| | | | | | | | |
|---|--------------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | LENGTH OF STAY (In this place) <u>since 7/29/1944</u> | | TOWN | | TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u> | | | | STREET ADDRESS <u>Pikesville 110 Reisterstown Road</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Donald C. Stoppenbach</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 1 1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb. 11, 1893</u> | 9. AGE last birthday <u>62</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <u>Electrical Engineer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> | | 11. BIRTHPLACE (State or foreign country) <u>Oregon</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Theodore N. Stoppenbach</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marie L. Bishop</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>Unknown</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT & ADDRESS <u>Eastern Shore State Hospital Records</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| <u>490X</u> IMMEDIATE CAUSE (A) <u>Lobar Pneumonia</u> | | | | | | <u>5 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) <u>Psychosis with Syphilitic Meningo-encephalitis (General Paresis)</u> | | | | | | <u>12 years plus</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work Not while at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 12/1, 1951, to 1/1, 1956, that I last saw the deceased alive on 12/31, 1955, and that death occurred at 12:02 AM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Robert H. Reddick</u> M.D. <u>State Hospital, Cambridge, Md.</u> | | | | DATE SIGNED <u>1/1/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-2-1956</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cem.</u> | | LOCATION (City, town, or county) (State) <u>Annapolis Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>John Macer Jr.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> | | ADDRESS <u>Don Annapolis Md.</u> | |
| DATE <u>Dec. 3, 1955</u> | | | | | | | |

CERTIFICATE OF DEATH

515

NEW YORK STATE DEPARTMENT OF HEALTH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED'S NEAREST RELATIVE

15. SIGNATURE OF DECEASED'S NEAREST RELATIVE

16. SIGNATURE OF DECEASED'S NEAREST RELATIVE

17. SIGNATURE OF DECEASED'S NEAREST RELATIVE

18. SIGNATURE OF DECEASED'S NEAREST RELATIVE

19. SIGNATURE OF DECEASED'S NEAREST RELATIVE

20. SIGNATURE OF DECEASED'S NEAREST RELATIVE

21. SIGNATURE OF DECEASED'S NEAREST RELATIVE

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49. SIGNATURE OF DECEASED'S NEAREST RELATIVE

50. SIGNATURE OF DECEASED'S NEAREST RELATIVE

BUREAU V. 2.

JAN 6 1936

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00532

532

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | STATE <u>Maryland</u> | | COUNTY <u>Dorchester</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | LENGTH OF STAY (in this place) <u>5 Weeks</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>5 Peachblossom Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Floyd W. TODD</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 4 1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>7-11-1879</u> | 9. AGE last birthday <u>76</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Toddville, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Riley Todd</u> | | | | 14. MOTHER'S MAIDEN NAME <u>not Known</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Floyd W. Todd 5 Peachblossom Ave</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 608X IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> | |
| ANTECEDENT CAUSE(S) DUE TO <u>URETHRAL STRICTURE</u> | | | | | | <u>10 yrs.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>PYELO NEPHROSIS</u> | | | | | | <u>4yrs.</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTENSIVE CARDIO VASCULAR DISEASE AND CHRONIC OSTEO ARTHRITIS</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>RECENT MYOCARDIAL INFARCTION-URETHRAL STRICTURE</u> | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept. 51</u> , 19 <u>51</u> , to <u>Jan. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 4</u> , 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>John Race</u> | | | | DATE SIGNED <u>1-9-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-7-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u> | | LOCATION (City, town, or county) (State) <u>Cambridge Dorchester Md.</u> | |
| 24. REC'D BY REGISTRAR <u>Jan. 7, 1956</u> | | REGISTRAR'S SIGNATURE <u>John Race</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u> | | | |
| DATE | | | | ADDRESS <u>Cambridge, Md.</u> | | | |

1935

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|----------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| JAMES H. HARRIS | | Male | | 45 | |
| 4. PLACE OF BIRTH | | 5. OCCUPATION | | 6. CAUSE OF DEATH | |
| BALTIMORE, MD | | LABORER | | HEART DISEASE | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| JAN 15, 1935 | | 10:30 AM | | HOME | |
| 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF WITNESSES | | 12. SIGNATURE OF DECEASED | |
| [Signature] | | [Signatures] | | [Signature] | |
| 13. MEDICAL CERTIFICATION | | 14. FUNERAL HOME | | 15. BURIAL PLACE | |
| [Text] | | [Text] | | [Text] | |
| 16. DATE OF INTERMENT | | 17. TIME OF INTERMENT | | 18. PLACE OF INTERMENT | |
| JAN 17, 1935 | | 1:00 PM | | [Text] | |
| 19. NAME OF FUNERAL HOME | | 20. NAME OF BURIAL PLACE | | 21. NAME OF MINISTER | |
| [Text] | | [Text] | | [Text] | |

BUREAU V. S.

RECEIVED

THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT FOR THE REGISTRATION OF DEATHS AND FOR THE ISSUANCE OF A BURIAL PERMIT. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE MINISTER OF THE FAITH TO WHICH HE BELONGS. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DATE OF DEATH.

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

547

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> | | LENGTH OF STAY (in this place) <u>8 mos. 3 das.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> | | <u>23-12-2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Eastern Shore State Hospital</u> | | | | STREET ADDRESS <u>-</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Norena</u> (First) <u>V.</u> (Middle) <u>Toomey</u> (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 2</u> <u>1956</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>2-10-87</u> | |
| 9. AGE last birthday <u>68</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Timothy J. Foley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Honore Agnes Barry</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u> | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT & ADDRESS <u>Eastern Shore State Hospital Records (and)</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION <u>Mrs. Jane Delano (Sister)</u> <u>103 East St. Delmar, Md.</u> | | | |
| 174x IMMEDIATE CAUSE (A) <u>Cancer of the Uterus</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>sev. Years</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) _____ | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Cerebral Arteriosclerosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>April 30, 1955</u> , to <u>Jan. 2</u> , 1956, that I last saw the deceased alive on <u>Jan. 2</u> , 1956, and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Simon Virkuty M.D.</u> | | | | ADDRESS (Street, city, town, state) <u>M.D. E.S.S. Hospital, Cambridge, Maryland 1-3-56</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Interment Burial</u> | | DATE THEREOF <u>Jan. 5th, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>Jan 5 1956</u> | | REGISTRAR'S SIGNATURE <u>John Mace, Jr.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co.</u> | | ADDRESS <u>Salisbury Md.</u> | |

10523

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

FILE

Reg. Off. No.

1. DEATH RECORDING NUMBER - CHECKED

2. PLACE OF DEATH

3. TIME OF DEATH

MARYLAND

COUNTY

4. SEX

DATE OF BIRTH

AGE

5. RACE

EDUCATION

INDUSTRY

6. OCCUPATION

RELIGION

CAUSE OF DEATH

7. MANNER OF DEATH

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF PHYSICIAN

8. PLACE OF BIRTH

9. PLACE OF DEATH

12. SIGNATURE OF WITNESSES

9. PLACE OF DEATH

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF WITNESSES

10. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF WITNESSES

12. SIGNATURE OF WITNESSES

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF WITNESSES

13. SIGNATURE OF WITNESSES

21. SIGNATURE OF WITNESSES

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27. SIGNATURE OF WITNESSES

28. SIGNATURE OF WITNESSES

17. SIGNATURE OF WITNESSES

29. SIGNATURE OF WITNESSES

30. SIGNATURE OF WITNESSES

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38. SIGNATURE OF WITNESSES

22. SIGNATURE OF WITNESSES

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51. SIGNATURE OF WITNESSES

52. SIGNATURE OF WITNESSES

29. SIGNATURE OF WITNESSES

53. SIGNATURE OF WITNESSES

54. SIGNATURE OF WITNESSES

30. SIGNATURE OF WITNESSES

55. SIGNATURE OF WITNESSES

56. SIGNATURE OF WITNESSES

BUREAU V. 3

JAN 5 1956

RECEIVED

200-1000000000

THIS CERTIFICATE IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS LOANED TO YOU FOR YOUR INFORMATION. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE RETURNED TO THE STATE DEPARTMENT OF HEALTH WHEN REQUESTED TO DO SO.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00534

548

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|--------------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | STATE <u>Maryland</u> COUNTY <u>Georgetown</u> | | CITY <u>Perryville</u> | | (If rural give location) | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY <u>9/30/54</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cambridge</u> | | | | TOWN | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u> | | | | STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Hallah L. Van Doren</u> | | | | 4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>28</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Jan. 22, 1875</u> | 9. AGE last birthday <u>81</u> yrs. | IF UNDER 1 YEAR (Month) (Day) (Year) IF UNDER 24 HRS. (Hours) (Min.) | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Augustus Van Doren</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hannah Force</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT & ADDRESS <u>Eastern Shore State Hospital Records</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 491X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 9/30, 1954, to 1/28, 1956, that I last saw the deceased alive on 1/27, 1956, and that death occurred at 2:15 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Robert H. Reddick</u> M.D. <u>State Hospital, Cambridge, Md.</u> | | | | DATE SIGNED <u>1/28/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | DATE THEREOF <u>1/28/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Green mount Cemetary</u> | | LOCATION (City, town, county) (State) <u>Baltimore, Maryland.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>John M. R. D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u> | | | |
| DATE <u>Jan. 28 '56</u> | | | | | | | |

CERTIFICATE OF DEATH

543

1. Name of deceased

William Henry

Baltimore

Age 20/24

2. Date of death

Jan. 28

San Francisco

Male

3. Date of birth

Jan. 22, 1925

Single

White

4. Cause of death

5. Place of death

Home

6. Days

Long pneumonia

7. Years

Chronic pneumonia

BUREAU V. 5

FEB 1 1956

RECEIVED

1/5

PM

2/30

6:15

50

1/27

8. State of death

State

549 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 116

Items 11, 13, 14 Film G192 1-31-56 et

| | | | |
|---|--------------------------------|---|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Dorchester</u> | MARYLAND | STATE <u>Maryland</u> COUNTY <u>Worcester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| X TOWN <u>rural Cambridge</u> | | TOWN <u>Ironshire</u> <u>23X-2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u> | | STREET ADDRESS (If rural give location) | |

| | | | |
|---|----------------------------|---|---|
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| <u>George Warren</u> | | <u>Jan 21 1956</u> | |
| 5. SEX: <u>M</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | 8. DATE OF BIRTH: <u>Dec 19 1877</u> |
| | | 9. AGE last birthday <u>78</u> yrs. | IF UNDER 1 YEAR: Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): <u>Berlin, Md.</u> |
| | | | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u> |

| | | | |
|---|--|--|--|
| 13. FATHER'S NAME: <u>Albert Warren</u> | | 14. MOTHER'S MAIDEN NAME: <u>Mary Rayne</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT & ADDRESS: <u>ES. State Hospital Records Cambridge</u> | |

| | | |
|---|--|----------------------------------|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u> <u>Unk</u> | | |
| DUE TO | | |
| ANTECEDENT CAUSE (S) (B) <u>General Arteriosclerosis</u> <u>Unk</u> | | |
| DUE TO | | |
| (C) | | |

| | |
|--|--|
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | |
|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc. | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from Oct 6, 1955, to Jan 21, 1956, that I last saw the deceased alive on Jan 21, 1956, and that death occurred at 11:35 AM, from the causes and on the date stated above.

| | | | | | |
|--|--|---|--|-------------------------------|--|
| SIGNATURE <u>Thomas T. Dredge</u> | | ADDRESS <u>M. D. Cambridge Md</u> | | DATE SIGNED <u>Jan 21 '56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | DATE THEREOF <u>1-23-56</u> | NAME OF CEMETERY OR CREMATORY <u>European</u> | LOCATION (City, town, or county) <u>Berlin</u> | (State) | |
| DATE REC'D BY LOCAL REGISTRAR <u>Jan 23, 1966</u> | REGISTRAR'S SIGNATURE <u>John H. Hagg, N. D.</u> | 24. FUNERAL DIRECTOR <u>Anna Bishop</u> | | ADDRESS <u>Berlin Md</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00536

533

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|-------------------------|---|-------------------------|--|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | STATE <u>Maryland</u> COUNTY <u>Dorchester</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY OR TOWN <u>Cambridge</u> | | LENGTH OF STAY (in this place) <u>40 years</u> | | CITY OR TOWN <u>Cambridge R.D. 1</u> | | STREET ADDRESS <u>Rural</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hospital</u> | | | | | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Fred</u> <u>Weber</u> | | | | <u>Jan. 19, 1956</u> <u>19</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>Jan. 13, 1872</u> | <u>84</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Retired Farmer Self Employed</u> | | | | <u>Baltimore</u> | | <u>U.S.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Fred Weber</u> | | | | <u>Wilhelmina Muth</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>none</u> | | <u>R.F.D. 2</u> <u>Elizabeth M. Weber, Cambridge, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| <u>526x</u> IMMEDIATE CAUSE (A) <u>BRONCHITIS</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>BRONCHIECTASIS</u> | | | | | | <u>20 YEARS</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | <u>OLD RHEUMATIC HEART DISEASE</u> <u>?</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>14 JAN, 1956</u>, to <u>19 JAN, 1956</u>, that I last saw the deceased alive on <u>19 JAN, 1956</u>, and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Walter E. Gurney, Jr.</u> | | | | ADDRESS (Street, city, town, state) <u>Cambridge Md.</u> | | DATE SIGNED <u>20 JAN 56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Jan 23, 1956</u> | | <u>Oak Lawn Cemetery</u> | | <u>Baltimore, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Jan 23, 1956</u> | | <u>John Thayer</u> | | <u>Wm. W. Kenneth R. Shuman</u> | | <u>Cambridge, Md.</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Form D-10-110

1. USUAL RESIDENCE (HOUSE OR APARTMENT)

2. PLACE OF DEATH

3. OCCUPATION

4. CAUSE OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BURIAL

8. NAME OF FUNERAL HOME

9. NAME OF PHYSICIAN

10. NAME OF NURSE

11. NAME OF DECEASED

12. SEX AND AGE

13. DATE OF BIRTH

BUREAU V. S.

JAN 24 1956

RECEIVED

WRAP-CLIPPING

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00537

534

CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|------------------|--|------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| 13 TOWN <u>Cambridge</u> | | 8 Weeks | | Cambridge | | 13 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 67 Cambridge Md. Hospital | | | | 407 Choptank Ave | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) (Middle) (Last) | | | | (Month) (Day) (Year) | | | |
| DORIS BRANNOCK WHEATLEY | | | | 1 13 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | White | M | 3-18-1924 | 31 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | | Woolfords, Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John A. Brannock | | | | Lula Fitzhugh | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | 217-16-9353 | | Howard T. Wheatley Cambridge, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 176X IMMEDIATE CAUSE (A) Generalized carcinomatosis | | | | | | 6 months | |
| ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma (squamous cell) of vagina | | | | | | 2 years | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Dec 1954 | | Carcinoma of vagina with metastasis | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Nov. 1954, to Jan. 13, 1956, that I last saw the deceased alive on Jan. 12, 1956, and that death occurred at 4 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Lewis M. Burdette</u> | | | | ADDRESS (Street, city, town, state) <u>City Office Bldg., Cambridge, Md.</u> | | DATE SIGNED <u>1/15/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 1-15-56 | | Dorchester Mem. Park | | Cambridge Dor. Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Jan 15, 1956 | | John H. B. D. | | LeCompte Funeral Service | | Cambridge, Md. | |

CERTIFICATE OF DEATH

Reg. No. 112

A. USUAL RESIDENT - (If not, state address)

PLACE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------|--|---------------|--|----------------|--|-----------------|--|-------------------------|--|-------------------------|--|---------------|--|---------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES H. HARRIS | | Male | | 65 | | 1875 | | Baltimore | | Maryland | | United States | | United States | |
| DATE OF DEATH | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | POST-MORTEM | |
| Jan 18 1936 | | 10:30 AM | | Heart Failure | | Natural | | Coronary Artery Disease | | Chest Pain | | Medicine | | None | |
| PLACE OF DEATH | | DATE OF DEATH | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | |
| Home | | Jan 18 1936 | | 10:30 AM | | Heart Failure | | Natural | | Coronary Artery Disease | | Chest Pain | | Medicine | |

THE MEDICAL CERTIFICATION

BUREAU V. S.

RECEIVED
JAN 18 1936

PHOTOGRAPH

THIS CERTIFICATE OF DEATH IS A STATISTICAL REPORT AND NOT A LEGAL DOCUMENT. IT IS NOT VALID UNLESS IT IS SIGNED BY A PHYSICIAN OR A CLERK OF THE HEALTH DEPARTMENT. IT IS NOT VALID UNLESS IT IS SIGNED BY A PHYSICIAN OR A CLERK OF THE HEALTH DEPARTMENT. IT IS NOT VALID UNLESS IT IS SIGNED BY A PHYSICIAN OR A CLERK OF THE HEALTH DEPARTMENT.

00538

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:

COUNTY DORCHESTER

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN CAMBRIDGELENGTH OF STAY
(in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY DorchesterCITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN AIRYSTREET ADDRESS (If rural, give location)
NONE3. NAME OF
DECEASED:

(Type or Print)

(First)

(Middle)

(Last)

ISAACWILSON

4. DATE

(Month)

(Day)

(Year)

OF
DEATH1231956

5. SEX:

M6. COLOR OR
RACE:C7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):SINGLE

8. DATE OF BIRTH:

4-17-1906

9. AGE last birthday:

49 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):WATERMAN10b. KIND OF BUSINESS OR
INDUSTRY:NONE

11. BIRTHPLACE (State or foreign country):

MARYLAND; DOB12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME:

ISAACWILSON

14. MOTHER'S MAIDEN NAME:

UNKNOWN15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service):NO

16. SOCIAL SECURITY No.:

217-10-8191

17. INFORMANT & ADDRESS:

LAURAADAMES

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause.

(a).....

DUE TO

DROWNING

Antecedent cause(s)

Diseases or conditions, if any,

(b).....

giving rise to the above cause DUE TO

stating underlying cause last

(c).....

INTERVAL BETWEEN
ONSET AND DEATH
IMMED.II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office, bldg., etc.)
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURYFound 1/30/56
10:45 AM

M.

21e. INJURY OCCURRED
While at work ☐ Not while at work ☐21f. HOW DID INJURY OCCUR? Left for work on dredge
boat at 11:30 P.M. 1/22/56. Circumstances of
his falling into creek unknown.22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Alfred R. MaryanorCHIEF MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☐

M. D.

ASSISTANT MEDICAL EXAM.

1/31/5623. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIALFebruary 2, 1956Cordtown MdDorchesterMd.

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 1, 1956JohnW. O. E.LeonW. HenryCambridge

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

FEB 6 1956

RECEIVED

Handwritten signatures and initials at the bottom of the page.

NO 215-10-2181 LARA ADAMS
ISAC Wilson UNKNOWN

WATERMAN NONE MARYLAND, D.C.A.

215-10-2181

WATERMAN
VIA
NONE

WATERMAN
VIA
NONE

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

536

CERTIFICATE OF DEATH

00539

Reg. Dist. No. 116

| | | | | | | | |
|---|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Dorchester</u> | | STATE <u>Maryland</u> | | COUNTY <u>Dor.</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u> | | LENGTH OF STAY (in this place) <u>entire life</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hospital</u> | | STREET ADDRESS (If rural give location) <u>R.F.D. 1</u> | | | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>Christopher</u> <u>Woodward</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> - <u>3</u> - <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>1-1-56</u> | 9. AGE last birthday <u>12</u> yrs. | IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Cambridge</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Charles Woodward</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Joan Wood</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT & ADDRESS <u>Charles Woodward, R.D. 1 Cambridge, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>776x</u> IMMEDIATE CAUSE (A) <u>Prematurity</u> | | | | | | <u>36 hrs</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO | | | | | | | |
| STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. el work) (Not while el work) | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1-1-1956</u> , to <u>1-3-1956</u> , that I last saw the deceased alive on <u>1-3-1956</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city, town, state) <u>Cambridge</u> | | DATE SIGNED <u>1-4-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u> | | DATE THEREOF <u>Jan. 3, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery, Secretary, Maryland</u> | | LOCATION (City, town, or county) (State) | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | ADDRESS <u>Cambridge, Md.</u> | |
| DATE <u>Jan 3, 1956</u> | | | | | | | |

2087243281

CERTIFICATE OF DEATH

285

Form No. 1

| | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|------------------|--|---------------|--|--------------------|--|----------------------------|--|-----------------------|--|----------------------------|--|--------------------------|--|------------------------------|--|----------------------------------|--|
| 1. Name of Deceased | | 2. Sex | | 3. Age | | 4. Date of Birth | | 5. Date of Death | | 6. Place of Death | | 7. Cause of Death | | 8. Medical Certificate | | 9. Signature of Physician | | 10. Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 15 1925 | | Jan 16 1955 | | Home | | Heart Disease | | [Signature] | | [Signature] | | [Signature] | |
| 11. Usual Residence | | 12. Occupation | | 13. Education | | 14. Marital Status | | 15. Religion | | 16. Race | | 17. Color | | 18. Birthplace | | 19. Date of Arrival in State | | 20. Date of Departure from State | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 21. Name of Informant | | 22. Relationship | | 23. Address | | 24. Telephone | | 25. Signature of Informant | | 26. Date of Statement | | 27. Signature of Registrar | | 28. Date of Registration | | 29. Signature of Physician | | 30. Date of Statement | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | | [Blank] | |

BUREAU V. S.

JAN 16 1955

RECEIVED